For the Period 7/1/97 - 6/30/98	# of Units	Unit Cost	Total Unit Cost
ACUTE REVIEW:			
Retrospective (non-outlier)	1,800	$79.00	$142,200
Retrospective Outlier	75	$272.08	$20,406
Rehabilitation	405	$43.70	$17,699
Swing Bed	850	$41.44	$35,224
Preprocedure	642	$49.26	$31,625
FA/DHS Referrals	60	$79.00	$4,740
Reconsiderations/ALJs	75	$295.04	$22,128
Outpatient	388	$41.44	$16,079
APGs	2,628	$41.44	$108,904
Observation	540	$41.44	$22,378
Focused	2,500	$41.44	$103,600
Total Acute Review	9,963		$524,983
Pass-Through (hospital printing & postage)			$20,000
Total Acute			$544,983
Quality Improvement Projects: (Acute Fee for Service, Acute Managed Care, Long Term Care)			$300,000

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For the Period 7/1/97 - 6/30/98	Total Cost
SPECIAL PROJECTS:	
Special Requests	$50,000
HMO External Review (3 @ $8,000 each)	$24,000
External Review of Mental Health Managed Care Contractor	$20,000
External Review of Substance Abuse Managed Care Contractor	$10,000
Automated MDS Data Management	$113,406
Total Special Projects	$217,406

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Nursing Facility

In Iowa, approximately one-half of the total nursing facility population are Medicaid recipients. IFMC has conducted utilization review in nursing facilities on behalf of the Department of Human Services (DHS) since 1979 in an effort to avoid Medicaid payments for unnecessary services.

The Nursing Home Reform section of the Omnibus Budget Reconciliation Act (OBRA) of 1987 requires Preadmission Screening and Annual Resident Review (PASARR) of all persons entering nursing facilities. The IFMC conducts the PASARR (Level I review) under contract with the Department, the Mental Health and Mental Retardation authority for the State of Iowa. This insures persons are placed appropriately in nursing facilities and receive the services appropriate to meet their needs.

Preadmission and continued stay reviews are conducted on all Medicaid eligible residents to determine whether the in-state and out-of-state admissions and continued stays are medically necessary and services are delivered in the most appropriate setting.

Interfacility transfers will not require preadmission reviews if the level of care (LOC) remains the same. Medicaid residents readmitted to nursing facilities (NFs), with no change in LOC, will not require readmission reviews.

Continued stay reviews are conducted no later than annually following admission. Medicaid residents who meet the definition of "inactive review status" are no longer reviewed. The "inactive review status" is defined as a Medicaid resident who:

- has resided in the facility for more than two years continuously, who is in stable condition; or
- ~~is 85 years of age or older and has been in the facility for one year or longer.~~

On-site visits are conducted by IFMC field staff at least every two years at each nursing facility to validate that the information provided by nursing facility staff during telephone admission review is supported by medical record documentation. Visits may be conducted more frequently if the facility has a large number of Medicaid recipients or residents with minimal care needs.

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Cases with adverse decisions resulting in payment consequences are eligible for additional levels of review. IFMC coordinates the reconsiderations and ALJ appeals.

An annual characteristic report will provide a summary of the clients residing in nursing facilities. DHS is interested in information related to outcomes of Medicaid recipients. The IFMC will include an analysis of clients' functional health status from available data in the annual characteristics report.

Private

The Nursing Home Reform section of the Omnibus Budget Reconciliation Act (OBRA) of 1987 requires PASARR of private pay persons entering nursing facilities. The IFMC conducts the PASARR Level I review under contract with the Department, the Mental Health and Mental Retardation authority for the State of Iowa. This ensures persons receive the services appropriate to meet their needs.

Reserve Bed Days

Payment for skilled nursing care may be approved to reserve a bed for the resident while the resident is absent overnight and if the resident has required facility care for three consecutive months.

Approval will be obtained from the IFMC and will be subject to the following limitations:

- Visitation: Approval for payment of absences for home visits or participation in the special social or rehabilitation programs. Approval must be obtained prior to the leave. Periods of paid absence shall not exceed 10 consecutive days at a time, with a maximum of 18 days in a calendar year.

- Hospitalization: Approval of payment of absences for hospitalizations that shall not exceed 10 days in any calendar month. Approval will not be given for over 10 days in any continuous hospital stay whether or not the stay extends into any succeeding months. Approval will be obtained following the hospitalization, and prior to the nursing facility submitting claims.

Recipient Health Education and Lock-In Program

IFMC has conducted utilization review for the Recipient Health Education Program (RHEP) and Lock-in (LI) program since 1991. The purpose of the program is to promote quality health care and to prevent harmful practices such as duplication of medical services, substance abuse, possible drug interaction, or emergency room utilization for non-emergency care. Recipients who are identified to overuse or misuse medical services are scheduled to receive a health education counseling session.

Potential recipients are selected by reviewing the Surveillance and Utilization Review Systems (SURS), the Medicaid Management Information System (MMIS), Summary Profile Reports, and Claim Profile Reports. Potential recipients may also be identified by referral from the state Drug Utilization Review (DUR) Commission and health care professionals.

The RHEP counseling session is held at the recipient's local DHS office or other local location at the discretion of the IFMC nurse. The RHEP provides health education counseling to reduce overutilization and misuse patterns, assure quality health care, and thereby reduce the cost of health care services to the state. The primary goal of the RHEP is to educate the recipient to use benefits wisely. Recipients are also encouraged to use only essential high quality services that are appropriate to the recipient's needs, are delivered timely, and are delivered in the appropriate setting.

After the initial RHEP, recipients may have their case closed, be sent health education material, have their utilization history reviewed again in six months, or be referred immediately for physician review. The referral for physician review is determined by whether the recipient attended the RHEP, the severity of misuse, and the potential for continued misuse of health care services.

Recipients identified for LI enrollment are scheduled for a counseling session similar to the RHEP session. The LI counseling session is conducted by explaining the same information covered in the RHEP session and allowing the recipient to select a LI provider(s). Recipients receive follow-up education as needed throughout the LI period and a scheduled counseling session at 12 months. At 24 months, a review is completed to determine, based on the recipient's past compliance, whether to discontinue LI or initiate referral for an additional 24 months.

IFMC corresponds with providers, the DUR Commission and DHS income maintenance workers to inform them of review outcomes and the action to be taken.

IFMC coordinates ALJ appeals at the request of the DHS.

IFMC will review and process paper claims for cases where the Social Services Number Information (SSNI) system does not reflect the current LI provider. A record of claims approved for payment will be submitted to the department monthly.

IFMC will initiate educational letters to recipients, and their managed health care providers regarding concerns noted during the medical review. This letter will follow all scheduled RHEP counseling sessions for managed health care recipients. Concerns of medical practice (i.e., quality, inappropriate billing practices, incorrect

medication dispensing) noted by review coordinators, and verified by physician reviewers or other health care professionals, will be referred to the IFMC clinical coordinators. If a determination of a potential or actual quality concern exists the IFMC will notify the DHS in writing. Supporting documentation, including documented telephone contacts between IFMC staff and providers and/or recipients, will be shared with DHS.

An annual characteristics report will provide a summary of clients involved in the RHEP and LI process.

Special Needs

The goal of this program is to expedite placement of individuals and reduce the amount of staff time for both receiving and discharging facility staff. Through a survey mailed to all Iowa health care facilities, the IFMC established and maintains a registry of facility profiles that provide information on the types of services provided in each facility.

Institutions needing to discharge a resident they anticipate as difficult-to-place, may call the IFMC for assistance. The IFMC staff gathers information regarding the patient's functional status and needs from the discharge planner and determines what type of facility and level of care would be most appropriate.

IFMC will update the registry of facility profiles annually.

Education

Support for Survey and Certification Agency

IFMC staff have presented educational seminars to long-term care professionals on a statewide and regional basis. IFMC provides information regarding long term care requirements and ways to improve performance. The professional staff may then train the other caregivers in the nursing facility.

During the 1996-1997 contract year, two topics were presented. Seventeen community college sites were selected for each topic, for a total of 34 educational sessions. To date no seminars have been canceled due to lack of response. Both topics developed this past year directly related to OBRA legislation for long term care facilities. The topics were selected based on suggestions by the Department of Inspections and Appeals (DIA) staff from survey results and comments from previous seminar evaluations.

IFMC will develop and provide educational programs for nursing facility staff, residents and their representatives. These programs will address two specific

topics, based on suggestions from the Department and previous education program participants. Ongoing Resident Assessment Instrument education will also be provided during the contract year. All educational programs will be developed and conducted by the IFMC, with direction from DIA staff. The DIA anticipates assuming responsibility for educational seminars related to the Survey and Certification program on July 1, 1998.

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SPECIALTY REVIEW SERVICES

Intermediate Care Facilities for the Mentally Retarded

The federal government mandates utilization review and an annual inspection of care by the designated state Medicaid agency in Intermediate Care Facilities for the Mentally Retarded. The IFMC conducts this review on a concurrent basis.

Residents will be monitored on admission, 90 days after admission for clients new to the facility, within 365 days after admission, and annually thereafter to determine appropriateness of placement and ongoing care. Reviews can be performed more often as indicated by clients' needs and facility interventions. Readmission reviews will not be required for clients returning to a facility, following a stay in an acute care facility or transfer from one ICF/MR facility to another. Routine 90 day reviews will not be required for readmissions from acute care facilities or for client transfers from one facility to another within the same corporation. In these situations, days will be assigned up to 344 days according to the specifics of the case.

Residents admitted to time limited stays at the state hospital schools will be monitored on admission for appropriateness for placement. Retrospective chart reviews will be completed on-site, following the client's discharge.

An on-site validation will be conducted in conjunction with an annual inspection of care. A report of the inspection of care evaluation will be prepared and forwarded to the facilities, the DHS, and the DIA.

One annual characteristics report will provide a summary of the clients residing in the ICF/MR facilities. The IFMC will include an analysis of clients' functional status from available data in the annual characteristics report.

The IFMC will provide quarterly reports of review activity for clients residing in ICF/MR facilities.

The IFMC will coordinate reconsideration reviews and hearings for adverse determinations.

IFMC is available to provide education sessions regarding the ICF/MR program to Central Points of Coordination (CPC) and target case managers. These sessions would be coordinated with the Iowa State Association of Counties.

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Specialty Facilities

The federal government mandates utilization review and an annual inspection of care by the designated state Medicaid agency in Specialty Hospitals. Specialty hospitals include the Mental Health Institutes (MHI), the Psychiatric Medical Institutes for Children (PMIC), and Nursing Facilities for the Mentally Ill (NF/MI).

The IFMC performs admission and subsequent reviews for medical necessity of placement and continued stay in these facilities. Annually, IFMC staff conduct on-site assessments of the quality of care delivered by each facility. An annual report of the inspection of care will be prepared and provided to the facility staff and the DHS. Quality of care will also be screened and evaluated with each review.

MHI: Admission and continued stay reviews will be conducted for individuals 65 years of age and over, and those 21 years of age and under who are not eligible for the Mental Health Access Plan (MHAP). Continued stay reviews will be conducted according to individual's needs.

PMIC: Admission and continued stay reviews will be conducted for individuals 21 years of age and under in PMIC facilities that provide treatment for primary mental health conditions. Continued stay reviews will be conducted according to the individual's needs.

NF/MI: Admission and continued stay reviews will be conducted for individuals 65 years of age and over. Continued stay reviews will be conducted according to the individual's needs.

IFMC coordinates the reconsiderations and ALJ appeals for cases involving adverse review determinations.

Waiver Programs

The federal government mandates utilization review for the five Home and Community Based Services (HCBS) waiver programs which include the following: Ill and Handicapped, Elderly, AIDS, Brain Injury, and Mental Retardation. One additional program for personal assistance has been mandated by legislation and is in the preimplementation phase. IFMC conducts these reviews to determine the level of care persons served under the waiver program would require if placed in an institution. In addition, IFMC will determine if services are available through the Brain Injured Waiver to sufficiently meet the client's needs.

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Ill and Handicapped Waiver

Ill and Handicapped Waiver reviews will be completed at the time of enrollment and annually thereafter. This program is projected to increase in size in the next year.

Elderly Waiver

The Elderly Waiver program is available to Medicaid persons who are 65 years of age or older and require ICF or SNF level of care.

Elderly Waiver reviews will be completed at the time of enrollment and annually thereafter. Recipients of this program must be enrolled in the Case Management Program for the Frail Elderly (CMPFE). Currently, the program is available in approximately three-fourths of all Iowa counties. DHS plans to extend this program to statewide access by 1998. This will result in continued rapid growth of this program.

IFMC will conduct on-site and telecommunication educational sessions for DHS and Area Agency on Aging personnel each time a new county enters the CMPFE.

Waiver Quality On-sites are conducted to validate the assessment information for the Elderly Waiver program. IFMC will participate in the regularly scheduled on-site audits process.

Elderly Waiver Prescreen

The IFMC will continue to collect data from each individual prescreening assessment tool completed for case managed clients by the Agencies on Aging. IFMC will use this data to create detailed reports for IDEA on a monthly and quarterly basis.

AIDS Waiver

AIDS Waiver reviews will be completed at the time of enrollment and every six months after final eligibility has been determined by DHS.

HCBS/MR Waiver

HCBS/MR Waiver reviews will be completed at the time of enrollment and annually thereafter. This program has grown rapidly, however, admission reviews are expected to level off after October 1997.

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